PRINTED: 03/29/2012 FORM APPROVED OMB NO. 0938-0391

CENTERS FOR MEDICARE & MEDICAID SERVICES					OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICA		IDENTIFICATION NUMBER:	A. BUILDING 01		COMPLETED
155704		B. WING		02/29/2012	
		<u> </u>		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF I	PROVIDER OR SUPPLIEF	₹		MAIN ST	
WALDRO	ON HEALTH AND R	REHAB CENTER		RON, IN 46182	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION
TAG			TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
K0000		,			
	A Life Safety Co	ode Recertification survey	K0000	This Plan of Correction is the center's	
	1	by the Indiana State		credible allegation of compliance.	
	-	lealth in accordance with		Preparation and/or execution of this plan of correction does not constitute admissio	n
	42 CFR 483.70(a	a).		or agreement by the provider of the truth	"
				of facts alleged or conclusions set forth in	
	Survey Date: 02	2/29/12		the statement of deficiencies. The plan of	
				correction is prepared and/or executed	
	Facility Number	: 000423		solely because it is required by the provisions of federal and state law.	
	Provider Number: 155704 AIM Number: 100290450 Surveyor: Phillip Komsiski, Life Safety Code Specialist				
	At this Life Safe	ety Code survey, Waldron			
		b Center was found not			
		rith Requirements for			
		Medicare/Medicaid, 42			
		3.70(a), Life Safety from			
	1	00 edition of the National			
	Fire Protection A	Association (NFPA) 101,			
	Life Safety Code	e (LSC), Chapter 19,			
	Existing Health	Care Occupancies and			
	410 IAC 16.2.				
	This one story fa	acility was determined to			
	1	11) construction and was			
		· ·			
	fully sprinklered. The facility has a fire alarm system with smoke detection in the				
	-				
	_	s open to the corridors and			
		lent rooms. The facility			
	has a capacity of 79 and had a census of				

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

000423

(X6) DATE

Any defiency statement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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	OF CORRECTION	IDENTIFICATION NUMBER:  155704	A. BUILDING B. WING	01	COME	LETED 0/2012		
NAME OF PROVIDER OR SUPPLIER WALDRON HEALTH AND REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE  505 N MAIN ST  WALDRON, IN 46182					
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) this survey	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
	Code Specialist-Me The facility was	Robert Booher, Life Safety dical Surveyor on 03/06/12 found not in compliance entioned regulatory						

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Event ID: B2X621

Facility ID: 000423

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	JLTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		a. BUILDING 01			COMPLETED		
	155704		B. WIN			02/29/	2012
NAME OF B	DOLUDED OD CLIDDLIED			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER			505 N MAIN ST				
	N HEALTH AND R		_		RON, IN 46182		
(X4) ID		TATEMENT OF DEFICIENCIES	ID PREFIX		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL			(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION
TAG <b>K0029</b>	NFPA 101	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCE		DATE
SS=E	One hour fire rate fire-rated doors) fire extinguishing	ODE STANDARD ed construction (with ¾ hour or an approved automatic g system in accordance with 3.5.4 protects hazardous					
	areas. When the extinguishing system areas are separated smoke resisting pare self-closing a protective plates inches from the base permitted.	e approved automatic fire stem option is used, the ated from other spaces by partitions and doors. Doors and non-rated or field-applied that do not exceed 48 pottom of the door are 3.2.1	17.00	200			02/20/2012
		ation and interview, the	K00	129	K 029		03/30/2012
	_	ensure 1 of 1 glass			How corrective action will be accomplished for those affected. No		
	sliding windows	separating the kitchen, a			residents were affected by this alleged		
	hazardous area, from the corridor would				deficient practice 2.) How corrective action		
	close automatica	lly with the fire alarm			will be accomplished for those residents having potential to be affected. No		
	system to mainta	in a smoke resistant			residents were affected by this alleged deficient practice. 3.) What measures will		
	barrier. This def	icient practice could					
	affect 12 residents observed in the dining room as well as visitors and staff.  Findings include:  Based on observation on 02/29/12 at 3:35				be put in place/systematic changes made to insure corrections. Stainless steel		
					self-closing door to be installed at opening between kitchen and dining room.		
					Requisition is in process thru vendor. 4.) How the facility plans to monitor performance to ensure deficient practices		
					do not reoccur. Maintenance director/Executive Director to ensure safe		
	•	nintenance Supervisor,			and accurate installation of required		
	_	liding windows protected			equipment. 5.) Date of completion 03/30/2012		
		the kitchen to the main	1		03/30/2012		
	dining room which	ch did not close					
	automatically up	on activation of the fire					
		he main dining room was					
		dor. Based on interview					
	on 02/29/12 at 3:37 p.m. with the		1				
	Maintenance Sup	-					
	iviamichance Sup	501 v1501, 1t was					

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	of Correction identification number: 155704	<b>A.</b> :	2) MULTIPLE CO BUILDING WING	01	COMP 02/29			
NAME OF PROVIDER OR SUPPLIER  WALDRON HEALTH AND REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 505 N MAIN ST WALDRON, IN 46182					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PERCEDED BY REGULATORY OR LSC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
	acknowledged the sliding glass window had to be manually shut and would not close automatically with activation of t fire alarm.	t I						
	3.1-19(b)							

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE			URVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING 01		COMPLE	COMPLETED	
155704		B. WING		02/29/2	2012	
			STRE	EET ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER		505	N MAIN ST		
WALDRON HEALTH AND REHAB CENTER				LDRON, IN 46182		
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL	PREFIX	CROSS-REFERENCED TO THE APPROP		COMPLETION
		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)		DATE
TAG K0056 SS=E	NFPA 101 LIFE SAFETY Constitute installed in according standard for the Systems, to prove portions of the burden properly maintain 25, Standard for Maintenance of Maintena	ation and interview, the ensure 2 of 3 sprinkler intenance room on south and a minimum of 6 feet in Section 5-6.3.4, ince Between Sprinklers" is shall be spaced not less inter. This deficient if feet 8 residents on south is sitors and staff it is ation on 02/29/12 at 3:40 mintenance Supervisor, in room on south hall had and son the west part of in were five feet apart. It is ew on 02/29/12 at 3:42 mintenance Supervisor, it is supervisor, it	K0056	K 056  1.) How corrective action will be accomplished for those affected. No residents were affected by this alleged deficient practice 2.) How corrective at will be accomplished for those resident having potential to be affected. No residents were affected by this alleged deficient practice. 3.) What measures to be put in place/systematic changes mat to insure corrections. Safe-Care to remextra sprinkler head from sited location (Completed 03/15/2012) 4.) How the facility plans to monitor performance to ensure deficient practices do not reocci Maintenance director/Executive Directive ensure removal of duplicate equipment Maintenance to ensure that any new sprinkler head installation is within this regulation  5.) Date of completion 03/30/2013	tion fill e ove	DATE 03/30/2012
	was acknowledged the two sprinkler					

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		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155704	(X2) MULTIPLE CO  A. BUILDING  B. WING	01	COMP. 02/29	
NAME OF PROVIDER OR SUPPLIER  WALDRON HEALTH AND REHAB CENTER			505 N I	ADDRESS, CITY, STATE, ZIF MAIN ST RON, IN 46182	P CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
	heads in the main hall were less tha	ntenance room on south on six feet apart.				
	3.1-19(b)					

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